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Morbidity and Mortality Weekly Report

Weekly July 23, 2004 / Vol. 53 / No. 28

Changing Patterns of Pneumoconiosis Mortality — United States, 1968–2000

Pneumoconioses are caused by the inhalation and deposition of mineral dusts in the lungs, resulting in pulmonary fibrosis and other parenchymal changes. Many persons with early pneumoconiosis are asymptomatic, but advanced disease often is accompanied by disability and premature death. Known pneumoconioses include coal workers' pneumoconiosis (CWP), silicosis, asbestosis, mixed dust pneumoconiosis, graphitosis, and talcosis. No effective treatment for these diseases is available (*1*). This report describes the temporal patterns of pneumoconiosis mortality during 1968–2000, which indicates an overall decrease in pneumoconiosis mortality. However, asbestosis increased steadily and is now the most frequently recorded pneumoconiosis on death certificates. Increased awareness of this trend is needed among health-care providers, employers, workers, and public health agencies.

The National Institute for Occupational Safety and Health (NIOSH) maintains a mortality surveillance system for respiratory diseases of occupational interest (*2*). The data are drawn from annual National Center for Health Statistics (NCHS) multiple-cause-of-death mortality files, which include all deaths in the United States since 1968. For this report, pneumoconiosis deaths were identified during 1968–2000, the most recent year for which complete data are available, and include any death certificates for which an *International Classification of Diseases* (ICD) code* for CWP, silicosis, asbestosis, or unspecified/other pneumoconiosis was listed as either the underlying or contributing cause of death. Age-adjusted death rates (per million population per year) for periods of interest were calculated by using the mid-year population as a denominator. Age standardization was performed by using the 2000 U.S. Census population.

During 1968–2000, pneumoconiosis was recorded on 124,846 death certificates. Comparing 1968–1981 with 1982–2000, death rates among males declined 36% for CWP and approximately 70% for both silicosis and unspecified/other pneumoconiosis, but increased nearly 400% for asbestosis. For both sexes, the decline was smaller among non-Hispanic blacks (26%) than among non-Hispanic whites (40%) for CWP but similar or greater for silicosis and unspecified/other pneumoconiosis, whereas the death rates for asbestosis increased 448% among blacks versus 342% among whites. Death rates among females were substantially lower than among males and, except for asbestosis, indicated decreases among both non-Hispanic whites and blacks. Asbestosis death rates increased among those aged ≥45 years; otherwise, death rates for the various pneumoconioses decreased regardless of age category.

The number of asbestosis deaths increased from 77 deaths (annual age-adjusted death rate: 0.54 per million population) in 1968 to 1,493 deaths (6.88 per million) in 2000; deaths for all other pneumoconioses decreased (Figure 1). CWP was the most frequently recorded pneumoconiosis from 1968 until 1998, when it was surpassed by asbestosis. Silicosis mortality declined steadily and, since 1993, was the least recorded category of pneumoconiosis. The geographic distributions of mortality for each type of pneumoconiosis for the 1968–1981 and 1982–2000 periods indicate that asbestosis increased substantially throughout the United States, particularly in the coastal states, where asbestos was used frequently in shipbuilding (Figure 2); CWP and the other pneumoconioses, which

INSIDE

* ICDA-8 (1968–1978), ICD-9 (1979–1998), and ICD-10 (1999–2000) (*2*).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2004;53:[inclusive page numbers].

tend to occur in the mining and industrial regions of the country, had either little change or a decline during the two study periods.

Information from death certificates regarding usual occupation and industry was available for deaths in selected states only for 1985–1999 (*2*) (Tables 1 and 2). During this period, ship and boat building/repairing was replaced by nonmetallic mineral/stone products as the industry with the highest proportionate mortality ratio (PMR) for asbestosis. In addition, explosives worker replaced mining machine operators as those whose occupation had the highest PMR for other/unspecified pneumoconiosis.

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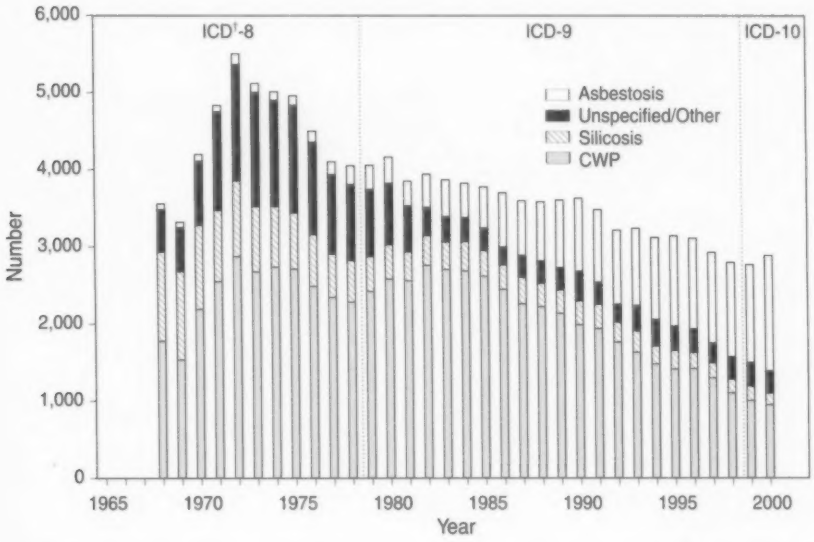
Editorial Note: The decline in overall pneumoconiosis mortality is attributed to reductions in CWP, silicosis, and other/unspecified pneumoconiosis mortality. The overall decline in CWP mortality follows the general reduction in the coal mining workforce since the 1920s. The Federal Coal Mine Health and Safety Act of 1969 introduced lower dust limits in the mining environment to protect the health of the nation's coal miners (*3*). Resulting lower dust levels have contributed to major reductions in disease among actively employed coal miners (*4*); however, the full impact of dust control on CWP mortality is not yet known. As with coal mining, the number of workers exposed to hazardous silica dust has declined through the loss of jobs in heavy industry. In addition, dust limits for silica in the United States also have been reduced steadily for approximately 30 years (*5*). Both job losses and reductions in exposures have contributed to the decline in silicosis mortality.

Asbestosis is the only major pneumoconiosis to demonstrate increased mortality. Because asbestosis mortality peaks 40–45 years after initial occupational exposure to asbestos (*6*), this upward trend reflects past exposure to asbestos fibers. Asbestos consumption increased substantially during and after World War II, with a peak in 1975 followed by a steep decrease beginning in the 1980s (*7*). Given the temporal pattern of usage and latency and survival considerations, asbestosis-related mortality is expected to increase for at least another decade. Asbestos-containing materials that continue to be used in some workplaces and remain in buildings represent a potential risk.

The findings in this report are subject to at least five limitations. First, occupation and industry codes that meet NCHS quality criteria are available only for certain states and for certain years. Thus, PMRs only reflect the industrial and occupational profiles of those states in those years. Second, these

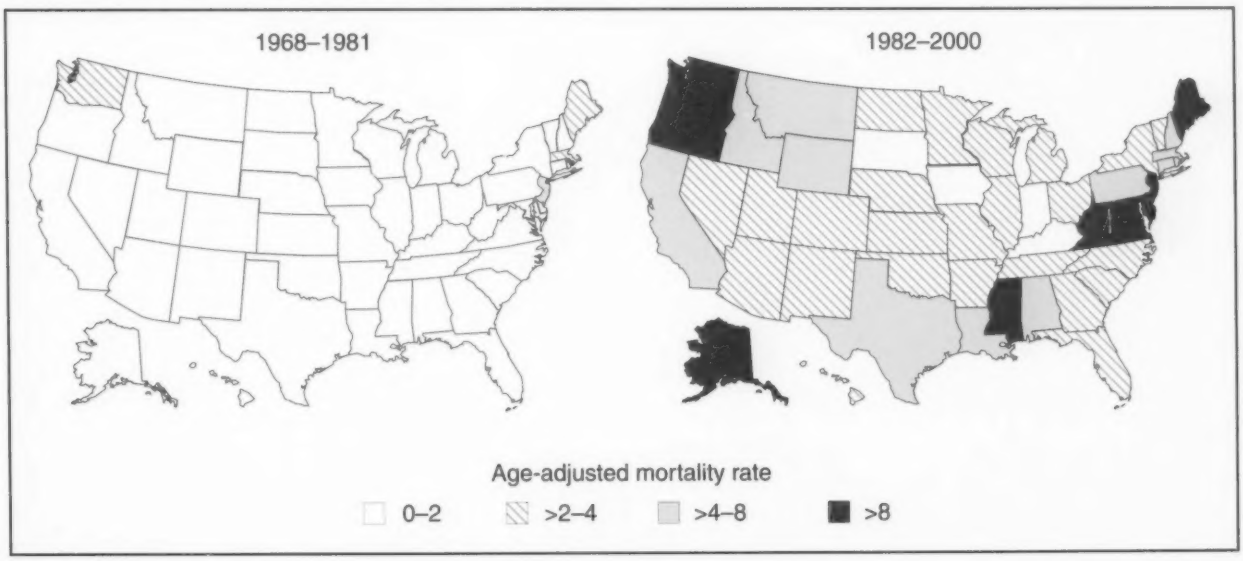
FIGURE 1. Number of deaths with any death certificate mention of asbestosis, coal workers' pneumoconiosis (CWP), silicosis, and unspecified/other pneumoconiosis among persons aged ≥15 years, by year — United States, 1968–2000*



* Because more than one type of pneumoconiosis might be reported on a death certificate as an underlying or contributing cause of death, the sum of individual types can exceed the overall, any-mention total. Thus, the total height of stacked bars slightly exceeds the total number of pneumoconiosis deaths.
† *International Classification of Diseases Revision.*

codes represent only the usual industry and occupation as entered on each death certificate, which is not always the industry and occupation in which the decedent's causative exposure occurred. Third, the state of residence at death is not always the state in which the decedent's causative exposure occurred, especially given the typically long latency and chronic course of the pneumoconioses. Fourth, slight differences exist in the ICD coding for asbestosis between the 9th and 10th revisions. In the 10th revision, the rubric for code J61 is "pneumoconiosis due to asbestos and other mineral fibers," whereas the rubric for the 8th and 9th revisions was simply "asbestosis." The overall effect of this change is unclear but might have resulted in an increase in the number of cases between the 9th and 10th revisions (i.e., between 1998 and 1999). Because occupational fiber exposures were predominantly to asbestos, the net effect of this change probably is small; the trend of increasing asbestosis deaths

FIGURE 2. Mortality rates* for asbestosis, by state — United States, 1968–1981 and 1982–2000



* Per 1,000,000 population.

TABLE 1. Highest proportionate mortality ratio (PMR) among U.S. residents aged ≥15 years, by industry, occupation, and type of pneumoconiosis — selected states, 1985–1992

Pneumoconiosis type	Industry (CIC*)	PMR†	(95% CI§)	Occupation (COC¶)	PMR	(95% CI)
CWP**	Coal mining (041)	51.3	(49.5–53.1)	Mining machine operators (616)	49.6	(47.9–51.5)
Asbestosis	Ship/Boat building/repairing (360)	24.2	(20.7–28.2)	Insulation workers (593)	152.1	(125.7–184.2)
Silicosis	Metal mining (040)	37.9	(30.1–47.8)	Metal/Plastic processing machine operators (725)	93.9	(46.9–167.9)
Other/Unspecified	Coal mining (041)	31.1	(28.4–34.1)	Explosives workers (615)	38.0	(12.3–88.7)

* Census Industry Code. Based on decedents' usual industry.
† Based on any mention of pneumoconiosis on death certificates and adjusted for age, sex, and race. PMR is defined as the observed number of deaths with the condition of interest in a specified industry/occupation, divided by the expected number of deaths with that condition (*2*).
§ Confidence interval.
¶ Census Occupation Code. Based on decedents' usual occupation.
** Coal workers' pneumoconiosis.

TABLE 2. Highest proportionate mortality ratio (PMR) among U.S. residents aged ≥15 years, by industry, occupation, and type of pneumoconiosis — selected states, 1993–1999

Pneumoconiosis type	Industry (CIC*)	PMR†	(95% CI§)	Occupation (COC¶)	PMR	(95% CI)
CWP**	Coal mining (041)	54.7	(52.6–56.9)	Mining machine operators (616)	52.8	(50.7–55.1)
Asbestosis	Nonmetallic mineral/stone products (262)	14.0	(10.2–18.8)	Insulation workers (593)	70.9	(54.9–91.7)
Silicosis	Metal mining (040)	41.7	(31.6–55.1)	Metal/Plastic processing machine operators (725)	83.3	(27.0–194.7)
Other/Unspecified	Coal mining (041)	44.8	(41.0–48.9)	Mining machine operators (616)	43.4	(39.6–47.6)

* Census Industry Code. Based on decedents' usual industry.
† Based on any mention of pneumoconiosis on death certificates and adjusted for age, sex, and race. PMR is defined as the observed number of deaths with the condition of interest in a specified industry/occupation, divided by the expected number of deaths with that condition (*2*).
§ Confidence interval.
¶ Census Occupation Code. Based on decedents' usual occupation.
** Coal workers' pneumoconiosis.

(Figure 1) indicates no evidence of any substantial change during 1998–1999. Finally, as with any data based solely on death certificate information, cause of death information is subject to potential errors associated with disease diagnosis, recording, and coding. For example, this information can be impacted by temporal changes in public and medical awareness and practice. In the years after the Farmington, West Virginia, mine disaster in 1968, the nation's attention focused on hardships suffered by coal miners, with a possible attendant rise in recording of CWP on death certificates. More recently, focus on asbestosis has increased, with a marked increase in asbestos-related litigation (*8*). This trend also has raised awareness of asbestosis, likely leading to its more frequent diagnosis and recording on death certificates. In addition, new technologies such as computed tomography are used increasingly, resulting in increased diagnostic sensitivity for pneumoconiotic diseases.

Despite these limitations, the national mortality data offer substantial benefits: they are national in scope, well documented, and readily available. These data are used to provide historical perspective on pneumoconiosis mortality and, given sufficient time lag, can be used to assess the effectiveness of preventive measures. They also can provide useful information on pneumoconiosis by location, industry, and occupation, suggesting ways in which to target preventive intervention and disease-management resources.

Considerable progress has been made toward elimination of the pneumoconioses. Nevertheless, certain pneumoconioses considered to be nearly eliminated are still occurring and causing deaths, even among young workers in the United States (*9,10*). Pneumoconioses are preventable, and efforts to eliminate these diseases should continue.

Acknowledgments

This report is based on contributions by G Syamlal, MPH, C Philips, RM Castellan, MD, National Institute for Occupational Safety and Health, CDC.

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(dis-'pach) 1 : a written message, particularly an official communication, sent with speed; see also *MMWR*.

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Acute Hemorrhagic Conjunctivitis Outbreak Caused by Coxsackievirus A24 — Puerto Rico, 2003

Acute hemorrhagic conjunctivitis (AHC) is an epidemic form of highly contagious conjunctivitis and is characterized by sudden onset of painful, swollen, red eyes, with conjunctival hemorrhaging and excessive tearing. Since 1981, when AHC was first detected in the Western Hemisphere (*1*), three major epidemics had occurred until 2003, all affecting the Caribbean. During August–October 2003, a fourth epidemic occurred in Puerto Rico (2000 population: 3.8 million). This report summarizes the outbreak investigation conducted by the Puerto Rico Department of Health (PRDOH), which documented an estimated 490,000 persons with illness, including >51,000 cases reported by physicians; demonstrated laboratory evidence of Coxsackievirus A24 (CA24); and determined that school-aged children (i.e., aged 5–18 years) and those living in crowded urban areas were at highest risk. To control outbreaks of AHC, prevention methods (e.g., frequent hand washing and avoidance of sharing towels and bedding) should be targeted to groups at highest risk, and information should be disseminated after the first report of AHC in the area.

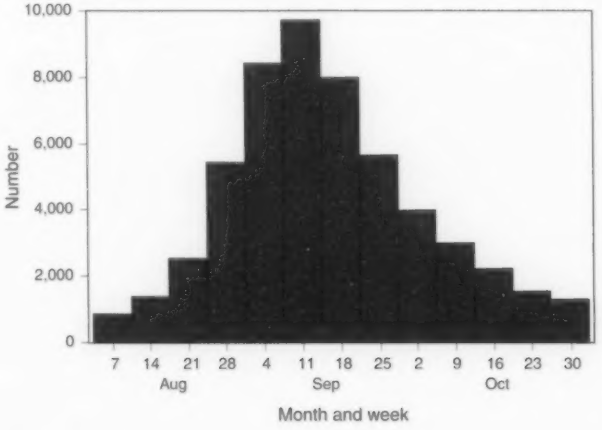
For surveillance purposes, PRDOH defines a case of AHC as physician-diagnosed conjunctivitis. To monitor the level of conjunctivitis, all health-care providers in Puerto Rico are contacted weekly to determine case counts of conjunctivitis treated during the week; providers typically report an average of 500 cases. However, in August 2003, reports of conjunctivitis increased weekly to a peak of nearly 10,000 during mid-September; reports returned to baseline in late October (Figure). During August–October 2003, health-care providers reported 51,850 cases of conjunctivitis.

Conjunctival swabs were obtained from a convenience sample of affected persons from five regions. The samples were sent to CDC, where, after testing negative for bacteria, they were tested for the presence of enterovirus RNA by using a 5-prime nontranslated region reverse transcriptase polymerase chain reaction (RT-PCR) assay. For positive specimens, the enterovirus was further characterized by RT-PCR amplification of the VP1 region of the virus and genetic sequencing and then identified as CA24 by comparison with reference sequences (*2,3*). Of 26 conjunctival swabs tested, 20 (77%) were positive for enterovirus; of these, 19 were identified as CA24 by VP1 sequencing. The remaining six conjunctival swabs were negative for enterovirus.

To further assess disease burden, identify persons at high risk, and estimate economic impact associated with this outbreak, PRDOH contacted approximately 340 households by calling randomly selected listed telephone numbers. One adult in each household was asked about the number and ages of household members with conjunctivitis. Adults also were asked about their workdays lost and use of medical services.

A total of 300 (88%) households participated in the survey, representing 902 household members; 114 (13%) reported having conjunctivitis during the outbreak period. The median age of household members was 21 years (range: 1–83 years). The attack rate was higher among school-aged children than among persons aged ≥19 years (24% versus 10%, respectively) (relative risk [RR] = 2.42; 95% confidence

FIGURE. Number* of reported cases of acute hemorrhagic conjunctivitis, by month and week of report — Puerto Rico, August 7–October 30, 2003



* N = 51,850.

interval [CI] = 1.72–3.40), among those living in urban than in rural areas (16% versus 10%, respectively; RR = 1.6; 95% CI = 1.18–2.35), and among close contacts of infected persons than among persons living alone (41% versus 6%, respectively; RR = 7.47; 95% CI = 1.92–29.12). Fifty-four (18%) households had at least one member with conjunctivitis. The attack rate was lowest for one-member households and increased with household size (correlation coefficient = 0.90; p = 0.005) (Table). Of 34 households with more than one member with conjunctivitis, 20 (59%) had an index patient who was of school age; overall, index patients were significantly younger than secondarily infected patients (median ages: 22 years versus 30 years; p = 0.034).

A total of 37 adult interviewees with conjunctivitis reported illnesses lasting a median of 7 days (range: 2–14 days); 24 (65%) sought medical care from a physician, nine (64%) of 14 employed interviewees missed work (median: 3 days; range: 0–10 days), and seven (87%) of eight students missed school (median: 2 days; range 0–10 days). Based on survey data, an estimated 490,000 persons (95% CI = 403,000–570,000) had conjunctivitis during August–October 2003, resulting in a combined 850 person-years of missed work (not including missed work for child care, which was not assessed) and 315,000 visits to physicians' offices. Combined, these factors were estimated to have cost Puerto Rico $30 million in lost worker production and health-care expenses during the 3-month period.

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Editorial Note: Since 1981, the Caribbean islands have had four major epidemics of AHC (*1,4,5*), including the outbreak described in this report. During the most recent previous outbreak in 1997, approximately 40,000 cases of AHC were reported in Puerto Rico (PRDOH, unpublished data, 1997). Immunity to the infection declines considerably within 7 years (*6,7*), and this loss of herd immunity to the virus might have permitted the widespread transmission observed during the 2003 outbreak.

TABLE. Attack rates for acute hemorrhagic conjunctivitis among households — Puerto Rico, 2003

Household size	No. households	No. cases	No. members	Attack rate
1	37	2	37	5%
2	90	15	180	8%
3	71	25	213	12%
4	60	35	240	15%
5	27	22	135	16%
6	10	9	60	15%
≥7	5	6	37	16%
Total	**300**	**114**	**902**	**13%**

The outbreak described in this report began in South America in the spring of 2003, affecting an estimated 200,000 persons in Brazil (*8*). The outbreak then moved into Central America and began affecting multiple islands in the Caribbean during the summer, including Puerto Rico in August (*9*). No states or other territories of the United States reported outbreaks of AHC during August–October 2003 and, since November, no other countries or states have reported an increase in cases.

AHC typically is caused by one of two enteroviruses (CA24 or enterovirus 70). This disease is transmitted person-to-person usually through contact with contaminated hands or through sharing of contaminated personal-care items. No specific treatment is available for AHC; however, the illness is self limiting, and severe complications are rare. Nonetheless, because of its extremely contagious nature, AHC can disrupt the local economy and require substantial health-care resources. This investigation documented increased health-care use and a substantial impact on workplace productivity in Puerto Rico, as measured by physician visits and combined years of work missed.

The findings in this report are subject to at least four limitations. First, the survey derives estimates for the entire island on the basis of a small survey sample, which could allow for wide variability. Second, the survey findings might not be representative of the entire population because only 76% of households in Puerto Rico have telephones, and 12% of those contacted refused to participate. Because crowding was documented in this study to be a risk for developing conjunctivitis and crowding might be more common among those not reached through a telephone survey, the total number of affected persons might have been underestimated. Third, although the households were selected randomly, the survey of individual members within the household was based on a convenience sample that might allow for some biases in the estimations. Finally, the broad case definition of conjunctivitis might have captured some noninfectious cases of conjunctivitis, resulting in an overestimation of the total number of persons affected. However, based on the large number of conjunctivitis reports relative to the baseline reporting, these noninfectious cases likely represent a small proportion.

Because the majority of adults are infected as a result of infection among their school-aged children, targeting future interventions to school-aged children can help to control spread. In addition to school-aged children, other groups at high risk (e.g., persons living in crowded urban areas and household contacts of infected persons) also should be

targeted for prevention messages. Recommended control measures include encouraging careful and frequent hand washing and avoiding sharing towels, bedding, makeup, and other personal items with persons with conjunctivitis.

Acknowledgments

This report is based on contributions by J Santiago-Ramos, MA, R Toledo-Lopez, MPH, D Andreu-Pietri, MS, S Claudio-Luciano, B Santiago-Gonzales, M Reyes-Cruz, LM Santiago-Bibiloni, MPH; Puerto Rico regional epidemiologists and nurses; Puerto Rico Dept of Health. R Moolenaar, MD, Div of Applied Public Health Training, Epidemiology Program Office; S Peñaranda, WA Nix, MS Oberste, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

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Progress Toward Poliomyelitis Eradication — Afghanistan and Pakistan, January 2003–May 2004

Since the 1988 World Health Assembly resolution to eradicate poliomyelitis, the number of countries where polio is endemic decreased from approximately 125 to six by the end of 2003 (*1*,*2*). In 2003, poliovirus importations were reported in 10 countries, including eight in West and Central Africa, one in Southern Africa (Botswana), and one in the Middle East (Lebanon) (*2*). Two countries where poliovirus remains endemic are Afghanistan and Pakistan, which are analyzed together because of their geographic proximity, frequent cross-border population movements, and genetically similar wild poliovirus (WPV) lineages. This report describes intensified

polio eradication activities in Afghanistan and Pakistan during January 2003–May 2004, summarizes progress made toward eradication, and highlights the remaining challenges to interrupting poliovirus transmission.

Routine and Supplementary Immunization Activities

Routine immunization programs in both Afghanistan and Pakistan remain inadequate. In 2002, reported overall coverage among infants with 3 doses of OPV (OPV3) was 48% in Afghanistan and 63% in Pakistan; moreover, wide variation existed at the subnational level (*3*).

The number and intensity of supplemental immunization activities (SIAs) in both Afghanistan and Pakistan were increased during 2003–2004, compared with previous years. In 2003, Pakistan conducted four rounds of national immunization days* (NIDs). Four rounds of subnational immunization days* (SNIDs), of which three covered >50% of the target population aged <5 years, also were conducted. In Afghanistan, four NID and three SNID rounds in 2003 were synchronized closely with rounds in Pakistan. During 2004, Pakistan has conducted three rounds of NIDs and one SNID round targeted at known virus reservoirs and districts with previously inadequate SIAs and low routine coverage. Afghanistan conducted two parallel NID rounds in the spring, followed by two rounds of "mopping-up" vaccination† in June and July, targeting the known virus reservoir in the southern and southeastern areas of the country.

The quality of SIAs is monitored in both countries by measuring process indicators during vaccination rounds and conducting immediate postcampaign coverage assessments. Monitoring identifies areas with inadequate SIAs and enables improvement of subsequent SIA rounds. The quality of SIAs in Pakistan has improved since January 2003 through the intensified efforts of government officials supplemented by development partners§ and additional United Nations agency support staff at the district level. The additional staff include approximately 100 district support officers assigned for 3–6 months and approximately 300 campaign support staff assigned for a 3-week period for the SIAs. In Afghanistan's southern and southeastern regions, 40 additional local staff were hired in early 2004 to support SIA planning, implementation, and monitoring at the district level, and to overcome access problems caused by deteriorating security. Process indicators and postcampaign coverage assessments demonstrate that SIA quality was maintained or improved in both countries during the previous 18 months.

In Pakistan, the proportion of acute flaccid paralysis (AFP) patients aged ≤24 months with >3 OPV doses (i.e., both routine and SIA doses) increased from 76% in 2003 to 83% during the first 5 months of 2004. This proportion remained at 81% for most of Afghanistan, except in the southern and southeastern regions, where it decreased from 80% (2003) to 76% (January–May 2004)¶.

AFP Surveillance

The quality of AFP surveillance is evaluated by two key indicators: the rate of reported AFP cases not caused by WPV (target: nonpolio AFP rate of ≥1 case per 100,000 children aged <15 years) and the proportion of persons with AFP with adequate stool specimens (target: ≥80%). The national nonpolio AFP rate for Pakistan in 2003 was 3.0 per 100,000 children aged <15 years, ranging from 2.5 in Punjab province to 4.2 in Balochistan province; as of May, the annualized rate in 2004 was 2.9. The percentage of persons with adequate stool specimens was 89% and 90% in 2003 and 2004 (provincial ranges: 85%–91% and 79%–92%), respectively.

Nonpolio AFP rates in Afghanistan were 4.0 per 100,000 children aged <15 years in 2003 and 4.2 in 2004, with the percentage of persons with adequate stool specimens at 88% in 2003 and 93% in 2004. Nonpolio AFP rates in 2003 ranged from 2.1 in the southeastern region to 5.5 in the western region.

The World Health Organization-accredited Regional Reference Laboratory at the National Institute of Health in Islamabad, Pakistan, performs virologic testing of stool specimens from both Afghanistan and Pakistan. The proportion of specimens with nonpolio enterovirus (NPEV) isolated, an indicator of the quality of stool-specimen transport and sensitivity of laboratory testing, was 22% and 25% in 2003 for Afghanistan and Pakistan, respectively; NPEV isolation rates during January–May 2004 were 19% for each country (Table).

Incidence of Polio

The number of confirmed cases of polio in Pakistan increased from 90 cases in 33 districts in 2002 to 103 cases in 48 districts in 2003. However, beginning in the second half

* National or subnational mass campaigns during a limited number of days in which 2 doses of OPV are administered to all children (usually aged <5 years), regardless of previous vaccination history, with an interval of 4–6 weeks between doses.

† More intensified campaigns that are conducted in areas of poliovirus transmission.

§ Polio eradication efforts in Afghanistan and Pakistan are supported by the governments of those countries, Japan, United Kingdom, Netherlands, Bill and Melinda Gates Foundation, United Nations Children's Fund (UNICEF), International Committee of the Red Cross, the International Committee of the Red Cross and Red Crescent Societies, Rotary International, U.S. Agency for International Development, World Health Organization, and CDC.

¶ National polio eradication programs analyze the OPV vaccination status (routine and supplemental doses) of children aged <5 years or ≤24 months with nonpolio AFP as a proxy for OPV coverage in these age groups.

TABLE. Number of confirmed wild poliovirus (WPV) cases and key surveillance indicators, by year — Afghanistan and Pakistan, January 2003–May 2004

Country	No. confirmed WPV cases	Serotype distribution of WPV isolated			No. acute flaccid paralysis (AFP) cases	Nonpolio AFP rate*	% persons with AFP with adequate specimens	% specimens with nonpolio enterovirus isolated	% results reported ≤28 days
		Type 1	Type 2	Type 3					
Afghanistan									
2003	8	5	0	3	599	4.0	88	22	98
2004†	3	2	0	1	280	4.2	93	19	99
Pakistan									
2003	103	72	0	31	2,270	3.0	89	25	98
2004†	16	11	0	5	944	2.9	90	19	99

* Per 100,000 children aged <15 years.
† January–May 2004.

of 2003, during peak transmission months, the number of cases began to decline; 55 cases were reported in the second half of 2003, compared with 62 during the same period in 2002. During the first 5 months of 2004, a total of 16 confirmed polio cases, 11 caused by WPV type 1 and five caused by WPV type 3, were reported, compared with 34 cases during the same period in 2003.

At the provincial level, progress has been variable. During the first half of 2003, transmission continued in four virus reservoirs: northern Sindh, where the most intense transmission occurred; southern Punjab; and two areas in Northwest Frontier Province (NWFP) (Figure). In the second half of 2003, during peak transmission months, one case was reported from the northern Sindh reservoir; however, transmission occurred in the Quetta area of Balochistan and intensified in NWFP. Subsequently, polio was reintroduced into the central Punjab area, which had been free of indigenous transmission of virus for >2 years; the virus originated in southern NWFP. In 2004, WPV circulation has been limited to four reservoirs that also had transmission in 2003. Transmission in central Punjab was limited and has not been detected since February. In addition, other transmission areas have not had cases in 2004, including the Quetta area of Balochistan province, Hyderabad district of Sindh province, and Lahore in central Punjab province. Karachi district has had one case in 2004.

Afghanistan reported eight polio cases in 2003, five caused by WPV type 1 and three by WPV type 3. Two WPV type 1 cases and one WPV type 3 case have been reported in 2004 (Table). The two WPV type 1 cases occurred in January and February in Helmand and Kandahar provinces, respectively, in southern Afghanistan; the WPV type 3 case occurred in May in Nangahar province in east Afghanistan. Sequence relationships among isolates suggest that the WPV type 1 virus strains transmitted in 2003 (including in Herat province in western Afghanistan) and in 2004 are part of the endemic WPV reservoir shared by southern and southeastern Afghanistan and Pakistan. The WPV type 3 viruses found in the south, southeast, and east since 2003 probably represent introductions from Pakistan.

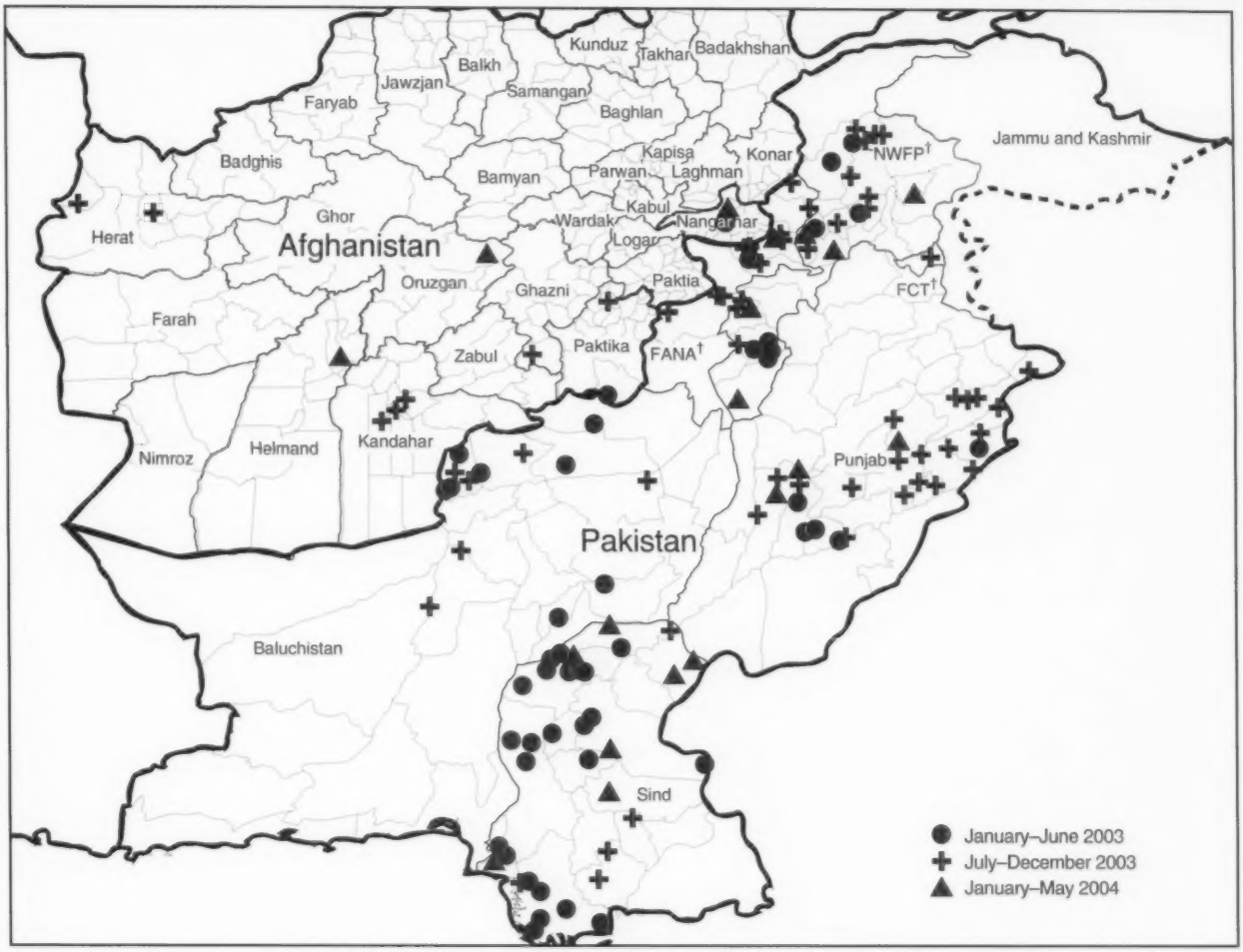
Reported by: *Ministry of Public Health; Country Office of the World Health Organization; United Nations Children's Fund (UNICEF), Kabul, Afghanistan. Regional Office for the Eastern Mediterranean Region, World Health Organization, Cairo, Egypt. National Institute of Health; Country Office of the World Health Organization; United Nations Children's Fund, Islamabad, Pakistan. Vaccines and Biologicals Dept, World Health Organization, Geneva, Switzerland. Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program, CDC.*

Editorial Note: Pakistan experienced an overall increase in the number of polio cases in 2003 compared with 2002; however, the increased number, intensity, and quality of SIAs in 2003 and 2004 have resulted in a decrease in polio incidence that began in mid-2003. In Pakistan, the majority of WPV circulation in 2004 has been limited to four areas, with intensity of transmission during the first 5 months of 2004 substantially lower than that in 2003. Notably, no cases have been reported in all of Balochistan province since October 2003. Central Punjab, where renewed transmission occurred during 2003, has not reported WPV since February 2004.

Challenges remain for the program in Pakistan. The most active areas of transmission are now in the tribal areas of the country, especially in NWFP. Cultural practices in areas of NWFP and in certain traditional communities in other provinces limit the involvement of women in SIAs, thereby reducing access to young children. The NWFP provincial government has been increasingly active in working with community and religious leaders toward better awareness and acceptance of polio vaccination and recruitment of community mobilizers.

In Afghanistan, progress toward improving the quality of SIAs is suggested by process indicators and coverage data. Data from 2004 suggest that SIA quality was maintained or improved in all areas except the southeastern and southern region, where performance decreased in 2004 compared with

FIGURE. Confirmed cases of poliomyelitis, by date of paralysis onset — Afghanistan and Pakistan*, January 2003–May 2004



* The boundaries, names, and designations on this map do not imply the expression of any opinion on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or the delimitation of its frontiers or boundaries. Dotted lines represent approximate borders for which full agreement might not exist.
† Federally Administered Northern Areas, Northwest Frontier Province, and Federal Capital Territory.

2003. The main constraint for polio eradication activities in Afghanistan is increasingly restricted access to extensive areas bordering Pakistan, potentially compromising the quality of both SIA activities and AFP surveillance.

Although thousands of Afghan refugee families have returned home from Pakistan, intense cross-border migration continues in both directions, favoring continuous virus movement between both countries. The two countries must continue to work together closely to interrupt poliovirus transmission, which can only occur if both countries maintain sensitive surveillance systems and further improve the quality of their SIAs, especially in areas where cultural practices limit access and in areas that are not secure.

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West Nile Virus Activity — United States, July 14–20, 2004

During the week of July 14–20, a total of 74 cases of human West Nile virus (WNV) illness were reported from seven states (Arizona, California, Florida, New Mexico, New York, South Dakota, and Texas).

During 2004, a total of 12 states have reported a total of 182 cases of human WNV illness to CDC through ArboNET (Table, Figure). Of these, 125 (69%) were reported from Arizona. A total of 94 (54%) of the 182 cases occurred in males; the median age of patients was 51 years (range: 1–84 years); the dates of illness onset ranged from April 23 to July 14; and four cases were fatal.

A total of 23 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET in 2004. Of these, 21 (91%) were reported from Arizona, and one each was reported from Iowa and New Mexico. Of the 23 PVDs, two persons aged 66 and 69 years subsequently had neuroinvasive illness, and five persons (median age: 52 years [range: 22–63 years]) subsequently had West Nile fever.

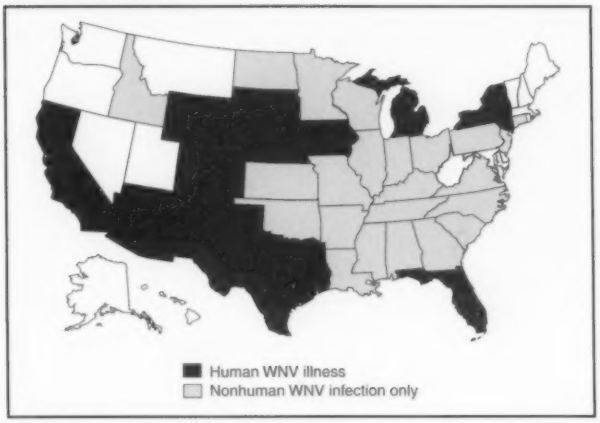
In addition, during 2004, a total of 1,264 dead corvids and 130 other dead birds with WNV infection have been reported from 31 states, and 39 WNV infections in horses have been reported from 10 states (Alabama, Arizona, California, Idaho, Missouri, North Carolina, Oklahoma, South Dakota, Tennessee, and Texas). WNV seroconversions have been reported in 173 sentinel chicken flocks from four states (Arizona, California, Florida, and Louisiana) and in a wild hatchling bird

TABLE. Number of human cases of West Nile virus (WNV) illness, by state — United States, 2004*

State	Neuroinvasive disease†	West Nile fever§	Other clinical/ unspecified¶	Total reported to CDC**	Deaths
Arizona	51	16	58	**125**	2
California	14	12	2	**28**	0
Colorado	1	11	0	**12**	0
Florida	3	1	0	**4**	0
Iowa	1	0	0	**1**	1
Michigan	1	0	0	**1**	0
Nebraska	0	1	0	**1**	0
New Mexico	0	4	0	**4**	0
New York	1	0	0	**1**	0
South Dakota	1	1	0	**2**	0
Texas	2	0	0	**2**	1
Wyoming	0	1	0	**1**	0
Total	**75**	**47**	**60**	**182**	**4**

* As of July 20, 2004.
† Cases with neurologic manifestations (e.g., West Nile meningitis, West Nile encephalitis, and West Nile myelitis).
§ Cases with no evidence of neuroinvasion.
¶ Illnesses for which sufficient clinical information was not provided.
** Total number of human cases of WNV illness reported to ArboNet by state and local health departments.

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2004*



* As of 3 a.m., Mountain Standard Time, July 20, 2004.

from Ohio. Three seropositive sentinel horses were reported from Puerto Rico. A total of 591 WNV-positive mosquito pools have been reported from 16 states (Arizona, Arkansas, California, Georgia, Illinois, Indiana, Louisiana, Michigan, Missouri, New Jersey, New Mexico, Ohio, Pennsylvania, Tennessee, Texas, and Virginia).

Additional information about national WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and at http://westnilemaps.usgs.gov.

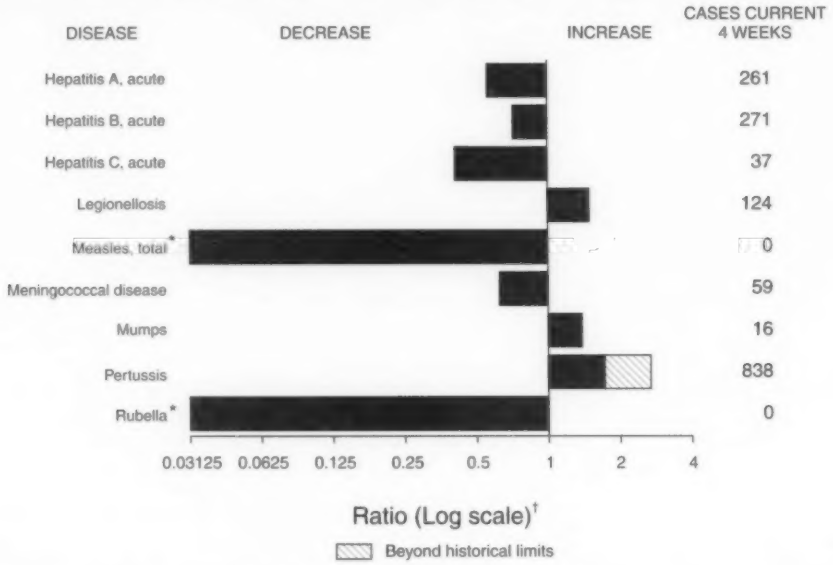
Notice to Readers

Satellite Broadcast on Rapid Testing for HIV

CDC and the Public Health Training Network will present a satellite broadcast and webcast, "Rapid Testing: Advances for HIV Prevention," on Thursday, November 18, 2004, beginning at 1 p.m. EST. The 2-hour forum will cover types of rapid tests for human immunodeficiency virus (HIV), implementation considerations such as testing women in labor, confirmatory testing, and quality assurance. A panel of experts will answer viewers' questions, which can be sent via fax during the broadcast or by e-mail after the broadcast.

Additional information and instructions for continuing education are available at http://www.cdcnpin-broadcast.org and through the CDC Fax Information System, telephone 888-232-3299, by entering document number 130042 and a return fax number. Organizations are responsible for setting up their own viewing sites and are encouraged to register their sites as soon as possible so that persons who wish to view the broadcast can access information online. Directions for establishing and registering a viewing site are available on the broadcast website. The broadcast also can be viewed live or later on computers with Internet and RealPlayer® capability at http://www.cdcnpin-broadcast.org. Videotapes and CD-ROMs of the broadcast can be ordered by telephone, 800-458-5231.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals July 17, 2004, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 28 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending July 17, 2004 (28th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	Hemolytic uremic syndrome, postdiarrheal†	50	66
Botulism:	-	-	HIV infection, pediatric†¶	88	126
foodborne	7	8	Measles, total	15**	32††
infant	40	34	Mumps	110	122
other (wound & unspecified)	6	10	Plague	-	1
Brucellosis†	60	46	Poliomyelitis, paralytic	-	-
Chancroid	18	35	Psittacosis†	4	6
Cholera	2	1	Q fever†	27	44
Cyclosporiasis†	93	34	Rabies, human	3	-
Diphtheria	-	-	Rubella	13	6
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	1
human granulocytic (HGE)†	75	96	SARS-associated coronavirus disease† §§	-	7
human monocytic (HME)†	63	79	Smallpox† ¶¶	-	NA
human, other and unspecified	3	17	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)† ¶¶	4	NA
California serogroup viral† §	4	13	Vancomycin-resistant (VRSA)† ¶¶	1	NA
eastern equine† §	-	4	Streptococcal toxic-shock syndrome†	62	115
Powassan† §	-	-	Tetanus	6	5
St. Louis† §	1	3	Toxic-shock syndrome	56	73
western equine† §	-	-	Trichinosis	2	-
Hansen disease (leprosy)†	40	43	Tularemia†	34	33
Hantavirus pulmonary syndrome†	9	14	Yellow fever	-	-

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update June 27, 2004.
** Of 15 cases reported, eight were indigenous, and seven were imported from another country.
†† Of 32 cases reported, 21 were indigenous, and 11 were imported from another country.
§§ Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (notifiable as of July 2003).
¶¶ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 2004, and July 12, 2003 (28th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile§	
	Cum. 2004¶	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	20,281	22,888	449,968	456,446	2,932	1,715	1,212	1,097	109	74
NEW ENGLAND	727	784	15,113	14,591	-	-	69	76	-	-
Maine	10	35	1,051	1,008	N	N	13	6	-	-
N.H.	26	18	890	838	-	-	16	10	-	-
Vt.	13	6	553	535	-	-	8	13	-	-
Mass.	235	326	7,368	5,701	-	-	21	35	-	-
R.I.	70	63	1,748	1,576	-	-	2	9	-	-
Conn.	373	336	3,503	4,933	N	N	9	3	-	-
MID. ATLANTIC	4,432	5,065	57,501	56,698	-	-	189	154	1	6
Upstate N.Y.	591	618	11,745	10,183	N	N	47	37	-	-
N.Y. City	2,341	2,315	17,146	18,648	-	-	46	53	1	-
N.J.	788	929	6,307	8,369	-	-	11	9	-	-
Pa.	712	1,203	22,303	19,498	N	N	85	55	-	6
E.N. CENTRAL	1,724	2,373	77,465	82,586	7	3	270	274	1	7
Ohio	237	419	19,799	22,327	-	-	76	38	-	4
Ind.	219	305	9,573	9,170	N	N	37	28	-	3
Ill.	852	1,117	19,531	25,716	-	-	13	40	-	-
Mich.	326	417	19,903	16,293	7	3	67	51	1	-
Wis.	90	115	8,659	9,080	-	-	77	117	-	-
W.N. CENTRAL	407	410	27,062	26,189	4	2	173	119	1	8
Minn.	95	77	5,197	5,708	N	N	59	46	-	2
Iowa	28	45	2,311	3,056	N	N	32	22	-	4
Mo.	181	203	10,687	9,440	3	1	25	10	-	-
N. Dak.	12	1	868	831	N	N	8	9	-	-
S. Dak.	6	6	1,320	1,306	-	-	23	21	1	1
Nebr.**	18	30	2,749	2,168	1	1	14	4	-	1
Kans.	67	48	3,930	3,680	N	N	12	7	-	-
S. ATLANTIC	6,151	6,435	86,182	85,516	-	3	232	154	3	4
Del.	83	133	1,514	1,631	N	N	-	3	-	-
Md.	690	729	9,984	8,688	-	3	10	8	-	-
D.C.	354	656	1,562	1,748	-	-	6	3	-	-
Va.	336	507	11,739	10,201	-	-	24	14	-	-
W. Va.	31	49	1,490	1,322	N	N	3	3	-	-
N.C.	344	632	15,198	13,806	N	N	40	19	-	-
S.C.**	376	435	8,207	7,366	-	-	9	2	-	1
Ga.	894	953	14,018	18,513	-	-	78	58	-	-
Fla.	3,043	2,341	22,470	22,241	N	N	62	44	3	3
E.S. CENTRAL	958	982	28,633	29,493	2	1	50	60	-	5
Ky.	107	83	2,993	4,377	N	N	19	13	-	-
Tenn.**	391	437	11,912	10,477	N	N	12	21	-	-
Ala.	233	249	5,560	7,966	-	-	12	23	-	5
Miss.	227	213	8,168	6,673	2	1	7	3	-	-
W.S. CENTRAL	2,544	2,352	57,800	56,660	2	-	37	28	3	33
Ark.	124	86	4,136	4,063	1	-	12	4	1	-
La.	576	400	12,418	11,241	1	-	-	1	-	8
Okla.	90	109	6,127	5,617	N	N	12	6	-	2
Tex.	1,754	1,757	35,119	35,739	-	-	13	17	2	23
MOUNTAIN	729	887	22,836	26,919	1,855	1,150	63	51	86	11
Mont.	5	10	1,107	1,120	N	N	13	12	-	-
Idaho	9	16	1,531	1,296	N	N	6	8	-	-
Wyo.	7	5	583	522	-	-	2	2	-	1
Colo.	137	211	4,876	6,778	N	N	26	11	1	10
N. Mex.	107	62	2,586	4,018	9	4	2	3	1	-
Ariz.	284	392	8,253	8,005	1,796	1,123	11	3	84	-
Utah	34	39	1,749	1,970	16	3	2	9	-	-
Nev.	146	152	2,151	3,210	34	20	1	3	-	-
PACIFIC	2,609	3,600	77,376	77,794	1,062	556	129	181	14	-
Wash.	214	247	9,299	8,278	N	N	14	14	-	-
Oreg.	133	145	4,376	4,077	-	-	17	22	-	-
Calif.	2,201	3,136	60,434	60,551	1,062	556	97	145	14	-
Alaska	15	13	1,938	2,047	-	-	-	-	-	-
Hawaii	46	59	1,329	2,841	-	-	1	-	-	-
Guam	2	5	-	375	-	-	-	-	-	-
P.R.	209	620	1,374	1,317	N	N	N	N	-	-
V.I.	6	17	143	186	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	32	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update June 27, 2004.

** Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 2004, and July 12, 2003 (28th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	852	806	99	100	76	61	7,816	8,360	155,672	171,078
NEW ENGLAND	53	42	26	21	13	4	696	609	3,517	3,630
Maine	2	4	-	-	-	-	68	65	134	117
N.H.	10	7	5	2	-	-	18	22	64	60
Vt.	4	4	-	-	1	-	66	44	46	42
Mass.	25	15	3	6	12	4	314	295	1,710	1,380
R.I.	5	1	1	-	-	-	54	55	475	486
Conn.	7	11	17	13	-	-	176	128	1,088	1,545
MID. ATLANTIC	103	102	14	9	14	13	1,783	1,739	18,156	21,651
Upstate N.Y.	49	36	7	4	4	6	592	431	3,882	3,895
N.Y. City	16	3	-	-	-	-	547	606	5,442	7,160
N.J.	14	15	3	1	4	-	169	248	2,531	4,622
Pa.	24	48	4	4	6	7	475	454	6,301	5,974
E.N. CENTRAL	165	210	19	18	9	9	931	1,493	31,270	35,997
Ohio	45	43	6	10	8	9	384	421	9,399	11,563
Ind.	13	31	-	-	-	-	-	-	3,330	3,428
Ill.	29	38	-	1	-	-	84	469	8,354	11,193
Mich.	39	34	3	-	1	-	314	334	7,937	6,722
Wis.	39	64	10	7	-	-	149	269	2,250	3,091
W.N. CENTRAL	181	124	16	17	13	9	924	832	8,642	8,830
Minn.	36	43	6	8	2	-	331	307	1,760	1,456
Iowa	52	20	-	-	-	-	130	113	412	727
Mo.	35	32	10	2	4	1	232	239	4,388	4,480
N. Dak.	5	5	-	3	5	2	16	21	63	37
S. Dak.	12	8	-	3	-	-	33	22	147	104
Nebr.	27	7	-	1	-	-	66	63	535	689
Kans.	14	9	-	-	2	6	116	67	1,337	1,337
S. ATLANTIC	69	61	14	22	19	15	1,274	1,263	38,187	41,887
Del.	1	1	N	N	N	N	26	19	483	621
Md.	16	3	1	1	2	1	55	57	4,343	4,050
D.C.	1	1	-	-	-	-	34	20	1,124	1,302
Va.	10	18	6	5	-	-	210	185	4,666	4,698
W. Va.	1	2	-	-	-	-	15	18	466	457
N.C.	-	-	-	-	9	14	N	N	8,071	7,718
S.C.	4	-	-	-	-	-	28	66	3,875	4,281
Ga.	15	15	3	3	-	-	373	399	5,938	9,015
Fla.	21	21	4	13	8	-	533	499	9,221	9,745
E.S. CENTRAL	37	34	1	-	7	4	163	171	12,193	14,347
Ky.	14	11	1	-	4	4	N	N	1,318	1,848
Tenn.	8	14	-	-	3	-	74	79	4,347	4,224
Ala.	8	6	-	-	-	-	89	92	3,395	4,912
Miss.	7	3	-	-	-	-	-	-	3,133	3,363
W.S. CENTRAL	43	37	1	2	1	3	131	144	21,542	23,230
Ark.	7	5	-	-	-	-	57	78	2,020	2,209
La.	2	1	-	-	-	-	19	8	5,580	6,453
Okla.	10	9	-	-	-	-	55	58	2,556	2,173
Tex.	24	22	1	2	1	3	-	-	11,386	12,395
MOUNTAIN	83	88	7	9	-	4	649	677	5,017	5,707
Mont.	8	3	-	-	-	-	22	35	36	57
Idaho	21	20	3	6	-	-	82	78	43	38
Wyo.	-	2	1	-	-	-	11	10	28	26
Colo.	16	25	1	1	-	4	218	195	1,450	1,563
N. Mex.	4	3	-	2	-	-	35	25	313	653
Ariz.	10	16	N	N	N	N	93	125	1,919	2,102
Utah	15	13	1	-	-	-	139	143	261	186
Nev.	9	6	1	-	-	-	49	66	967	1,082
PACIFIC	118	108	1	2	-	-	1,265	1,432	17,148	15,799
Wash.	41	28	-	1	-	-	158	139	1,401	1,485
Oreg.	14	19	1	1	-	-	212	185	572	549
Calif.	55	60	-	-	-	-	819	1,022	14,542	12,888
Alaska	1	1	-	-	-	-	32	42	309	292
Hawaii	7	-	-	-	-	-	44	44	324	585
Guam	N	N	-	-	-	-	-	-	-	38
P.R.	-	1	-	-	-	-	13	112	111	149
V.I.	-	-	-	-	-	-	-	-	49	48
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	3	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 2004, and July 12, 2003 (28th Week)*

Reporting area	*Haemophilus influenzae*, invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years						A	
	All serotypes		Serotype b		Non-serotype b		Unknown serotype			
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,062	1,047	9	15	53	70	106	122	2,835	3,359
NEW ENGLAND	98	70	1	1	5	5	3	3	473	148
Maine	7	2	-	-	-	-	-	1	9	5
N.H.	13	8	-	-	2	-	-	-	11	9
Vt.	5	6	-	-	-	-	1	-	8	4
Mass.	43	39	1	1	-	5	2	1	404	74
R.I.	3	4	-	-	-	-	-	1	10	11
Conn.	27	11	-	-	3	-	-	-	31	45
MID. ATLANTIC	226	215	-	1	3	2	27	28	316	713
Upstate N.Y.	75	75	-	1	3	2	3	7	45	60
N.Y. City	47	36	-	-	-	-	9	6	113	260
N.J.	40	47	-	-	-	-	3	7	61	114
Pa.	64	57	-	-	-	-	12	8	97	279
E.N. CENTRAL	172	173	-	2	6	3	27	33	248	335
Ohio	69	43	-	-	2	-	11	7	29	65
Ind.	33	28	-	-	4	-	1	2	15	29
Ill.	39	66	-	-	-	-	9	18	96	96
Mich.	13	13	-	2	-	3	5	1	85	112
Wis.	18	23	-	-	-	-	1	5	23	33
W.N. CENTRAL	64	69	2	-	3	6	4	8	111	99
Minn.	27	25	1	-	3	6	-	1	28	32
Iowa	1	-	1	-	-	-	-	-	31	16
Mo.	21	29	-	-	-	-	2	7	33	29
N. Dak.	3	2	-	-	-	-	-	-	1	-
S. Dak.	-	1	-	-	-	-	-	-	2	-
Nebr.	5	1	-	-	-	-	-	-	7	7
Kans.	7	11	-	-	-	-	2	-	9	15
S. ATLANTIC	252	212	-	-	16	8	19	14	544	717
Del.	8	-	-	-	-	-	2	-	5	4
Md.	41	48	-	-	4	4	-	-	74	70
D.C.	-	-	-	-	-	-	-	-	4	24
Va.	23	30	-	-	-	-	1	5	53	46
W. Va.	10	8	-	-	-	-	3	-	2	11
N.C.	37	17	-	-	5	1	1	1	44	35
S.C.	2	4	-	-	-	-	-	1	21	23
Ga.	69	40	-	-	-	-	12	4	188	290
Fla.	62	65	-	-	7	3	-	3	153	214
E.S. CENTRAL	37	46	-	1	-	2	7	4	83	96
Ky.	3	3	-	-	-	1	-	-	13	17
Tenn.	23	27	-	-	-	1	5	3	46	54
Ala.	11	16	-	1	-	-	2	1	6	12
Miss.	-	-	-	-	-	-	-	-	18	13
W.S. CENTRAL	45	51	1	1	5	7	1	4	214	337
Ark.	1	5	-	-	-	1	-	-	38	19
La.	7	17	-	-	-	2	1	4	13	32
Okla.	36	27	-	-	5	4	-	-	17	6
Tex.	1	2	1	1	-	-	-	-	146	280
MOUNTAIN	127	113	3	6	15	18	13	12	254	257
Mont.	-	-	-	-	-	-	-	-	4	2
Idaho	5	3	-	-	-	-	2	1	11	9
Wyo.	-	1	-	-	-	-	-	-	3	1
Colo.	28	20	-	-	-	-	3	4	26	37
N. Mex.	25	14	-	-	5	3	3	1	8	11
Ariz.	48	60	-	6	7	8	1	4	162	147
Utah	10	9	2	-	1	4	2	2	33	17
Nev.	11	6	1	-	2	3	2	-	7	33
PACIFIC	41	98	2	3	-	19	5	16	592	657
Wash.	3	6	2	-	-	4	1	1	34	35
Oreg.	27	24	-	-	-	-	1	2	41	35
Calif.	3	43	-	3	-	15	2	8	499	577
Alaska	4	18	-	-	-	-	1	5	4	6
Hawaii	4	7	-	-	-	-	-	-	14	4
Guam	-	-	-	-	-	-	-	-	-	2
P.R.	-	-	-	-	-	-	-	-	11	46
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 2004, and July 12, 2003 (28th Week)*

Reporting area	Hepatitis (viral, acute), by type: B Cum. 2004	B Cum. 2003	C Cum. 2004	C Cum. 2003	Legionellosis Cum. 2004	Legionellosis Cum. 2003	Listeriosis Cum. 2004	Listeriosis Cum. 2003	Lyme disease Cum. 2004	Lyme disease Cum. 2003
UNITED STATES	3,146	3,635	618	575	696	822	263	288	5,608	7,432
NEW ENGLAND	173	175	4	3	14	30	11	16	626	1,168
Maine	1	1	-	-	-	1	3	2	53	-
N.H.	23	11	-	-	1	5	1	2	52	20
Vt.	2	2	1	3	1	1	-	-	15	9
Mass.	94	122	3	-	4	13	2	9	189	726
R.I.	3	4	-	-	2	2	1	-	80	121
Conn.	50	35	U	U	6	8	4	3	237	292
MID. ATLANTIC	545	434	67	71	183	195	56	52	4,159	5,082
Upstate N.Y.	52	41	7	9	38	40	22	11	1,470	1,315
N.Y. City	57	134	-	-	13	20	7	12	-	108
N.J.	277	112	-	-	34	25	10	10	919	1,627
Pa.	159	147	60	62	98	110	17	19	1,770	2,032
E.N. CENTRAL	276	275	42	87	171	168	41	38	128	452
Ohio	71	79	3	6	90	89	17	9	47	24
Ind.	8	15	2	3	13	10	8	1	3	7
Ill.	33	36	7	14	10	19	-	12	-	36
Mich.	141	117	30	60	56	38	15	11	8	-
Wis.	23	28	-	4	2	12	1	5	70	385
W.N. CENTRAL	215	164	204	123	15	37	6	8	118	97
Minn.	26	21	5	4	1	3	2	2	52	60
Iowa	10	4	-	-	3	6	1	-	12	13
Mo.	146	112	199	118	9	18	2	3	44	20
N. Dak.	3	-	-	-	1	1	-	-	-	-
S. Dak.	-	2	-	-	1	1	-	-	-	-
Nebr.	16	15	-	1	-	2	1	3	6	2
Kans.	14	10	-	-	-	6	-	-	4	2
S. ATLANTIC	981	979	102	91	167	226	40	57	486	501
Del.	19	6	-	-	4	7	N	N	49	93
Md.	82	63	13	6	32	51	4	8	302	318
D.C.	13	1	1	-	5	1	-	-	2	4
Va.	113	83	12	2	17	44	6	7	34	28
W. Va.	6	10	17	1	3	3	1	2	2	5
N.C.	94	95	7	6	18	16	12	10	57	28
S.C.	54	84	7	23	1	5	-	2	5	1
Ga.	318	308	7	6	24	20	7	16	7	9
Fla.	282	329	38	47	63	79	10	12	28	15
E.S. CENTRAL	216	238	58	45	33	57	17	10	26	27
Ky.	29	40	17	7	11	23	4	1	11	5
Tenn.	95	97	25	10	13	19	8	1	9	8
Ala.	34	49	1	5	8	11	3	6	1	1
Miss.	58	52	15	23	1	4	2	2	5	13
W.S. CENTRAL	101	591	78	100	34	37	20	33	13	59
Ark.	31	50	1	3	-	2	1	1	2	-
La.	32	79	43	60	3	1	2	1	1	6
Okla.	21	34	2	1	2	4	-	1	-	-
Tex.	17	428	32	36	29	30	17	30	10	53
MOUNTAIN	273	319	27	21	42	37	12	17	11	6
Mont.	2	8	2	1	1	2	-	1	-	-
Idaho	6	4	-	1	5	3	1	-	2	2
Wyo.	7	22	-	-	4	2	-	-	2	-
Colo.	25	48	4	5	5	7	3	6	1	-
N. Mex.	10	23	7	-	-	2	-	2	-	1
Ariz.	151	149	3	4	10	9	-	5	1	-
Utah	28	22	2	-	14	8	1	2	5	1
Nev.	44	43	9	10	3	4	7	1	-	2
PACIFIC	366	460	36	34	37	35	60	57	41	40
Wash.	28	36	11	11	6	4	6	4	3	-
Oreg.	60	73	9	5	N	N	5	2	16	9
Calif.	263	336	13	17	31	31	48	48	22	30
Alaska	13	3	-	-	-	-	-	-	-	1
Hawaii	2	12	3	1	-	-	1	3	N	N
Guam	-	3	-	1	-	-	-	-	-	-
P.R.	20	72	-	-	1	-	-	-	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 2004, and July 12, 2003 (28th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	563	558	817	1,034	5,043	3,807	2,693	3,741	449	276
NEW ENGLAND	46	15	38	49	669	406	278	254	11	3
Maine	5	1	8	5	2	9	29	22	-	-
N.H.	1	2	3	3	26	25	11	10	-	-
Vt.	3	-	1	-	42	35	10	18	-	-
Mass.	22	12	21	31	571	311	118	95	9	3
R.I.	2	-	1	2	16	7	15	31	1	-
Conn.	13	-	4	8	12	19	95	78	1	-
MID. ATLANTIC	128	135	101	127	1,277	377	243	456	33	19
Upstate N.Y.	20	28	25	29	929	155	210	181	1	-
N.Y. City	58	66	17	29	76	55	4	5	5	6
N.J.	22	24	21	18	96	67	-	62	9	10
Pa.	28	17	38	51	176	100	29	208	18	3
E.N. CENTRAL	49	59	110	167	817	315	26	46	18	8
Ohio	16	11	44	44	249	120	10	17	10	4
Ind.	3	1	15	27	52	30	4	5	5	-
Ill.	7	27	12	46	146	28	9	7	-	2
Mich.	15	16	32	29	68	39	3	15	3	2
Wis.	8	4	7	21	302	98	-	2	-	-
W.N. CENTRAL	39	26	59	79	449	175	260	380	55	22
Minn.	18	13	16	18	94	59	32	16	-	1
Iowa	2	3	11	16	37	43	40	50	-	2
Mo.	8	3	17	30	182	39	16	6	45	17
N. Dak.	3	1	1	1	99	2	36	36	-	-
S. Dak.	1	1	2	1	9	3	10	80	3	-
Nebr.	2	-	2	6	3	3	53	69	6	2
Kans.	5	5	10	7	25	26	73	123	1	-
S. ATLANTIC	149	133	156	178	290	256	1,038	1,511	190	167
Del.	3	-	12	8	5	2	9	23	-	-
Md.	34	34	7	17	58	39	50	217	21	46
D.C.	8	7	4	3	2	-	-	-	-	-
Va.	12	13	10	18	85	58	233	290	8	4
W. Va.	-	4	5	3	5	5	32	49	1	4
N.C.	9	8	23	19	46	75	352	428	130	67
S.C.	7	3	12	14	28	15	77	118	9	9
Ga.	26	31	10	19	9	20	159	198	12	33
Fla.	50	33	73	77	52	42	126	188	9	4
E.S. CENTRAL	18	12	34	49	63	85	66	118	54	45
Ky.	1	1	4	10	15	20	14	21	-	-
Tenn.	3	4	10	12	30	44	21	81	25	26
Ala.	11	5	10	13	12	13	28	15	15	5
Miss.	3	2	10	14	6	8	3	1	14	14
W.S. CENTRAL	49	71	80	118	278	281	624	778	76	8
Ark.	6	4	12	10	9	18	29	25	46	-
La.	2	2	22	31	7	7	-	1	3	-
Okla.	2	3	5	10	17	29	71	137	27	2
Tex.	39	62	41	67	245	227	524	615	-	6
MOUNTAIN	22	17	36	53	548	548	65	80	8	4
Mont.	-	-	3	2	18	1	11	11	2	1
Idaho	1	1	4	6	18	35	-	3	1	1
Wyo.	-	1	2	2	11	119	-	1	1	2
Colo.	6	11	9	12	277	189	9	12	-	-
N. Mex.	1	-	5	7	64	34	2	5	1	-
Ariz.	6	2	6	20	109	98	41	40	1	-
Utah	5	1	4	-	41	53	2	5	2	-
Nev.	3	1	3	4	10	19	-	3	-	-
PACIFIC	63	90	203	214	652	1,364	93	118	4	-
Wash.	4	13	20	18	347	303	-	-	-	-
Oreg.	10	7	41	34	245	257	2	4	2	-
Calif.	48	67	137	149	44	797	83	109	2	-
Alaska	-	-	1	4	8	1	8	5	-	-
Hawaii	1	3	4	9	8	6	-	-	-	-
Guam	-	-	-	-	-	1	-	-	-	-
P.R.	-	-	4	7	2	1	31	37	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 2004, and July 12, 2003 (28th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive			
							Drug resistant, all ages		Age <5 years	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	15,888	18,063	5,406	12,104	2,887	3,804	1,315	1,298	352	450
NEW ENGLAND	831	933	127	156	135	348	15	70	7	5
Maine	37	55	2	6	6	20	2	-	1	-
N.H.	51	65	5	4	15	23	-	-	N	N
Vt.	26	34	2	5	8	16	7	6	1	2
Mass.	482	559	79	104	89	151	N	N	N	N
R.I.	48	40	8	4	17	5	6	10	5	3
Conn.	187	180	31	33	-	133	-	54	U	U
MID. ATLANTIC	2,215	2,147	622	1,265	477	674	98	84	70	66
Upstate N.Y.	512	439	301	166	162	254	46	43	49	48
N.Y. City	552	585	178	200	71	93	U	U	U	U
N.J.	303	379	87	211	90	136	-	-	2	2
Pa.	848	744	56	688	154	191	52	41	19	16
E.N. CENTRAL	1,898	2,657	377	1,045	589	944	319	301	95	196
Ohio	595	668	84	190	162	223	229	200	56	69
Ind.	188	248	87	74	69	86	90	101	22	17
Ill.	321	1,026	87	563	131	239	-	-	-	76
Mich.	416	357	60	146	200	274	N	N	N	N
Wis.	378	358	59	72	27	122	N	N	17	34
W.N. CENTRAL	1,179	1,031	191	386	201	229	11	9	50	52
Minn.	275	254	24	47	103	110	-	-	37	36
Iowa	238	176	40	25	N	N	N	N	N	N
Mo.	333	330	81	201	41	49	8	6	5	2
N. Dak.	19	23	2	6	9	11	-	3	2	4
S. Dak.	52	39	7	9	9	18	3	-	-	-
Nebr.	77	74	9	63	10	21	-	-	4	5
Kans.	185	135	28	35	29	20	N	N	2	5
S. ATLANTIC	3,768	4,057	1,446	3,770	560	615	670	679	26	12
Del.	19	46	3	144	3	6	4	1	N	N
Md.	362	390	62	297	118	156	-	4	15	-
D.C.	24	15	22	32	4	5	4	-	3	4
Va.	438	413	69	208	45	79	N	N	N	N
W. Va.	88	55	-	-	17	27	80	43	8	8
N.C.	465	532	153	470	84	66	N	N	U	U
S.C.	241	208	204	239	35	30	54	101	N	N
Ga.	603	712	327	792	116	122	150	154	N	N
Fla.	1,528	1,686	606	1,588	138	124	378	376	N	N
E.S. CENTRAL	947	1,135	308	531	135	131	77	96	-	-
Ky.	161	191	42	59	46	34	20	11	N	N
Tenn.	217	342	109	180	89	97	57	85	N	N
Ala.	278	268	127	178	-	-	-	-	N	N
Miss.	291	334	30	114	-	-	-	-	-	-
W.S. CENTRAL	1,395	2,629	1,245	3,332	164	175	36	51	71	69
Ark.	235	271	35	53	10	5	6	17	7	4
La.	241	367	158	265	1	1	30	34	12	14
Okla.	170	180	264	481	43	56	N	N	30	32
Tex.	749	1,811	788	2,533	110	113	N	N	22	19
MOUNTAIN	1,129	1,044	388	491	336	327	20	4	33	50
Mont.	73	49	4	2	-	1	-	-	-	-
Idaho	88	96	6	11	5	13	N	N	N	N
Wyo.	25	49	1	1	6	1	6	3	-	-
Colo.	268	259	67	79	86	86	-	-	29	36
N. Mex.	109	99	59	101	59	83	5	-	-	8
Ariz.	363	312	209	243	151	121	N	N	N	N
Utah	117	99	21	26	28	21	7	1	4	4
Nev.	86	81	21	28	1	1	2	-	-	-
PACIFIC	2,526	2,430	702	1,128	290	361	69	4	-	-
Wash.	248	289	57	94	34	29	-	-	N	N
Oreg.	201	216	35	54	N	N	N	N	N	N
Calif.	1,851	1,774	583	958	206	267	N	N	N	N
Alaska	37	49	4	4	-	-	-	-	N	N
Hawaii	189	102	23	18	50	65	69	4	-	-
Guam	-	24	-	23	-	-	-	-	-	-
P.R.	84	317	1	6	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	3	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 17, 2004, and July 12, 2003 (28th Week)*

Reporting area	Syphilis: Primary & secondary		Syphilis: Congenital		Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	3,769	3,758	177	244	5,043	6,436	124	168	8,889	9,908
NEW ENGLAND	101	117	1	-	192	216	14	17	587	2,140
Maine	2	4	-	-	-	11	-	-	179	636
N.H.	3	14	-	-	9	10	-	1	-	-
Vt.	-	-	-	-	-	5	-	-	408	487
Mass.	67	75	-	-	118	103	12	9	-	105
R.I.	14	12	-	-	17	27	1	2	-	3
Conn.	15	12	1	-	48	60	1	5	-	909
MID. ATLANTIC	534	435	28	39	1,050	1,147	32	28	58	12
Upstate N.Y.	47	17	2	5	117	130	3	4	-	-
N.Y. City	284	251	9	22	547	615	10	15	-	-
N.J.	83	83	17	12	204	210	9	8	-	-
Pa.	120	84	-	-	182	192	10	1	58	12
E.N. CENTRAL	411	523	34	43	607	585	6	20	3,849	3,734
Ohio	121	111	1	2	105	100	2	-	1,001	923
Ind.	32	25	8	9	71	69	-	4	-	-
Ill.	136	219	3	16	277	275	-	9	-	-
Mich.	106	156	22	16	115	110	3	7	2,501	2,246
Wis.	16	12	-	-	39	31	1	-	347	565
W.N. CENTRAL	78	94	2	4	221	248	3	4	118	39
Minn.	14	31	-	-	84	90	2	2	-	-
Iowa	4	7	-	-	19	12	-	1	N	N
Mo.	40	32	1	4	61	70	1	1	2	-
N. Dak.	-	-	-	-	3	-	-	-	73	39
S. Dak.	-	1	-	-	5	16	-	-	43	-
Nebr.	4	3	-	-	15	11	-	-	-	-
Kans.	16	20	1	-	34	49	-	-	-	-
S. ATLANTIC	997	997	23	47	1,034	1,224	23	31	1,485	1,487
Del.	3	4	1	-	-	-	-	-	4	16
Md.	191	155	3	8	136	121	5	8	-	-
D.C.	38	31	1	-	40	-	-	-	17	18
Va.	55	47	1	1	110	124	2	11	377	407
W. Va.	2	1	-	-	12	11	-	-	862	881
N.C.	90	90	5	9	134	148	3	5	N	N
S.C.	58	61	1	4	108	85	-	-	225	165
Ga.	153	268	1	12	11	274	9	3	-	-
Fla.	407	340	10	13	483	461	4	4	-	-
E.S. CENTRAL	211	175	14	9	300	357	4	2	2	-
Ky.	24	22	1	1	54	61	2	-	-	-
Tenn.	76	72	7	2	106	119	2	1	-	-
Ala.	91	65	4	5	107	124	-	1	-	-
Miss.	20	16	2	1	33	53	-	-	2	-
W.S. CENTRAL	603	435	28	38	321	1,004	7	12	1,240	2,142
Ark.	20	26	-	1	63	52	-	-	-	-
La.	110	56	-	-	-	-	-	-	42	9
Okla.	19	30	2	1	75	73	-	-	-	-
Tex.	454	323	26	36	183	879	7	12	1,198	2,133
MOUNTAIN	183	161	30	24	250	203	5	4	1,550	354
Mont.	-	-	-	-	4	-	-	-	-	-
Idaho	13	4	2	1	-	5	-	-	-	-
Wyo.	1	-	-	-	1	2	-	-	21	37
Colo.	19	22	-	3	57	48	1	3	1,163	-
N. Mex.	26	32	1	4	14	28	-	-	67	-
Ariz.	110	94	27	16	115	82	2	1	-	-
Utah	3	2	-	-	23	17	1	-	299	317
Nev.	11	7	-	-	36	21	1	-	-	-
PACIFIC	651	821	17	40	1,068	1,452	30	50	-	-
Wash.	54	40	-	-	122	124	2	2	-	-
Oreg.	17	26	-	-	40	61	1	2	-	-
Calif.	577	748	17	40	828	1,179	21	46	-	-
Alaska	-	1	-	-	18	31	-	-	-	-
Hawaii	3	6	-	-	60	57	6	-	-	-
Guam	-	1	-	-	-	30	-	-	-	84
P.R.	66	114	3	8	14	49	-	-	156	341
V.I.	4	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	10	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending July 17, 2004 (28th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	549	381	114	32	14	8	40
Boston, Mass.	161	104	34	11	6	6	12
Bridgeport, Conn.	28	20	7	1	-	-	1
Cambridge, Mass.	13	10	1	2	-	-	2
Fall River, Mass.	22	19	2	1	-	-	3
Hartford, Conn.	66	50	12	3	-	1	3
Lowell, Mass.	22	18	4	-	-	-	-
Lynn, Mass.	11	7	3	1	-	-	-
New Bedford, Mass.	22	17	4	1	-	-	2
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	65	46	9	7	3	-	4
Somerville, Mass.	7	2	5	-	-	-	-
Springfield, Mass.	42	30	7	2	3	-	1
Waterbury, Conn.	27	20	5	1	1	-	2
Worcester, Mass.	63	38	21	2	1	1	10
MID. ATLANTIC	2,168	1,476	458	140	44	45	114
Albany, N.Y.	47	31	12	3	-	1	3
Allentown, Pa.	25	21	2	2	-	-	2
Buffalo, N.Y.	81	50	17	5	6	3	5
Camden, N.J.	25	13	8	3	-	1	1
Elizabeth, N.J.	12	9	2	1	-	-	-
Erie, Pa.	51	43	6	1	1	-	1
Jersey City, N.J.	21	14	7	-	-	-	-
New York City, N.Y.	1,064	729	226	68	21	16	58
Newark, N.J.	65	25	28	7	4	-	5
Paterson, N.J.	17	9	3	2	-	3	-
Philadelphia, Pa.	333	213	81	23	5	11	6
Pittsburgh, Pa.§	25	19	2	1	1	2	1
Reading, Pa.	22	18	4	-	-	-	1
Rochester, N.Y.	142	97	27	10	2	6	11
Schenectady, N.Y.	19	14	3	2	-	-	1
Scranton, Pa.	35	29	4	1	1	-	1
Syracuse, N.Y.	121	97	12	8	2	2	16
Trenton, N.J.	31	20	8	2	1	-	-
Utica, N.Y.	14	10	3	1	-	-	2
Yonkers, N.Y.	18	15	3	-	-	-	-
E.N. CENTRAL	2,141	1,396	494	138	54	58	141
Akron, Ohio	44	30	7	4	3	-	8
Canton, Ohio	30	26	3	1	-	-	4
Chicago, Ill.	346	192	96	33	15	9	28
Cincinnati, Ohio	72	47	16	5	1	3	5
Cleveland, Ohio	266	185	60	9	3	9	12
Columbus, Ohio	227	147	50	20	7	3	12
Dayton, Ohio	107	77	23	5	1	1	6
Detroit, Mich.	186	89	66	18	8	5	13
Evansville, Ind.	32	25	7	-	-	-	1
Fort Wayne, Ind.	71	54	11	4	1	1	5
Gary, Ind.	23	12	7	1	1	2	1
Grand Rapids, Mich.	49	31	7	4	3	4	6
Indianapolis, Ind.	220	150	49	8	4	9	12
Lansing, Mich.	43	29	10	2	1	1	5
Milwaukee, Wis.	107	72	20	11	-	4	8
Peoria, Ill.	41	31	5	-	1	4	5
Rockford, Ill.	52	34	15	3	-	-	3
South Bend, Ind.	47	34	9	-	2	2	2
Toledo, Ohio	108	75	25	6	2	-	2
Youngstown, Ohio	70	56	8	4	1	1	3
W.N. CENTRAL	593	371	135	45	23	19	31
Des Moines, Iowa	26	20	3	2	1	-	1
Duluth, Minn.	22	13	7	2	-	-	-
Kansas City, Kans.	43	28	11	1	1	2	3
Kansas City, Mo.	87	54	19	8	3	3	3
Lincoln, Nebr.	35	28	6	1	-	-	2
Minneapolis, Minn.	67	33	14	7	7	6	1
Omaha, Nebr.	111	69	24	7	5	6	8
St. Louis, Mo.	77	45	21	9	2	-	7
St. Paul, Minn.	60	40	13	3	3	1	2
Wichita, Kans.	65	41	17	5	1	1	4
S. ATLANTIC	1,183	731	268	113	41	30	71
Atlanta, Ga.	74	47	19	6	1	1	2
Baltimore, Md.	168	91	50	14	8	5	12
Charlotte, N.C.	137	83	30	11	5	8	9
Jacksonville, Fla.	149	96	32	11	8	2	4
Miami, Fla.	100	52	25	16	5	2	12
Norfolk, Va.	51	33	6	9	1	2	2
Richmond, Va.	50	28	12	5	2	3	3
Savannah, Ga.	61	38	19	4	-	-	7
St. Petersburg, Fla.	75	44	18	7	5	1	3
Tampa, Fla.	199	140	32	17	5	5	11
Washington, D.C.	100	62	23	13	1	1	3
Wilmington, Del.	19	17	2	-	-	-	3
E.S. CENTRAL	827	546	189	60	22	10	59
Birmingham, Ala.	190	123	46	14	6	1	15
Chattanooga, Tenn.	84	60	19	1	3	1	5
Knoxville, Tenn.	78	51	18	7	2	-	1
Lexington, Ky.	60	39	15	5	1	-	3
Memphis, Tenn.	152	98	40	9	2	3	10
Mobile, Ala.	84	60	14	5	2	3	9
Montgomery, Ala.	47	34	6	5	1	1	7
Nashville, Tenn.	132	81	31	14	5	1	9
W.S. CENTRAL	1,437	910	350	105	42	30	70
Austin, Tex.	88	61	16	6	-	5	3
Baton Rouge, La.	25	10	5	10	-	-	-
Corpus Christi, Tex.	49	31	13	1	2	2	1
Dallas, Tex.	201	112	60	12	10	7	5
El Paso, Tex.	55	42	9	4	-	-	3
Ft. Worth, Tex.	121	81	29	8	2	1	10
Houston, Tex.	418	254	107	39	12	6	32
Little Rock, Ark.	53	32	13	3	4	1	1
New Orleans, La.	54	30	16	6	2	-	-
San Antonio, Tex.	206	143	43	9	7	4	14
Shreveport, La.	42	29	11	1	1	-	1
Tulsa, Okla.	125	85	28	6	2	4	-
MOUNTAIN	906	594	204	64	25	18	58
Albuquerque, N.M.	95	62	20	9	3	1	3
Boise, Idaho	40	34	3	1	1	1	1
Colo. Springs, Colo.	68	49	13	2	3	1	4
Denver, Colo.	103	50	30	12	7	4	9
Las Vegas, Nev.	237	152	57	17	7	3	17
Ogden, Utah	37	27	7	1	1	1	1
Phoenix, Ariz.	30	19	7	3	1	-	-
Pueblo, Colo.	28	19	9	-	-	-	8
Salt Lake City, Utah	117	76	25	9	1	6	11
Tucson, Ariz.	151	106	33	10	1	1	4
PACIFIC	1,781	1,207	382	109	47	36	151
Berkeley, Calif.	12	11	-	1	-	-	2
Fresno, Calif.	146	107	24	7	6	2	7
Glendale, Calif.	17	17	-	-	-	-	2
Honolulu, Hawaii	65	55	7	1	1	1	8
Long Beach, Calif.	78	52	16	6	2	2	10
Los Angeles, Calif.	340	238	72	20	5	5	40
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	142	92	38	8	3	1	4
Sacramento, Calif.	220	141	46	14	13	6	17
San Diego, Calif.	152	96	36	13	4	3	17
San Francisco, Calif.	131	78	36	12	2	3	15
San Jose, Calif.	150	103	32	5	7	3	9
Santa Cruz, Calif.	30	14	11	4	-	1	1
Seattle, Wash.	144	94	33	9	2	6	7
Spokane, Wash.	52	36	15	-	1	-	4
Tacoma, Wash.	102	73	16	9	1	3	8
TOTAL	11,585¶	7,612	2,594	806	312	254	735

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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☆U.S. Government Printing Office: 2004-633-140/00029 Region IV ISSN: 0149-2195